| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155377 | A. BUILDING 00<br>B. WING | 08/14/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SEYMOUR CROSSING | 707 S JACKSON PARK DR<br>SEYMOUR, IN 47274 |

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| F000000 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00128887 and IN00130258.<br><br>This visit was in conjunction with the Investigation of Complaints IN00133821 and IN00134053.<br><br>Complaint IN00128887 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, and F246.<br><br>Complaint IN00130258 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: August 5, 6, 7, 8, 9, 12, 13, and 14, 2013.<br><br>Facility number: 000272<br>Provider number: 155377<br>AIM number: 100274710<br><br>Survey team:<br>Diana Sidell RN, TC<br>Sunny Jungclaus RN<br>Jennifer Carr RN<br>Angel Tomlinson RN (August 5, 6, 7, and 8, 2013) | F000000 | The facility repectfully requests paper review IDR for tag F 224, F 225, F 226, F 279, F 281, F 514. The facility has evidence for the following tags to support the deficiencies should not have been sited. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Census bed type:<br>SNF/NF: 80<br>Total: 80<br><br>Census payor type:<br>Medicare: 5<br>Medicaid: 69<br>Other: 6<br>Total: 80<br><br>Supplemental sample: 2<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed on 8/22/2013 by Cheryl Fielden, RN. | | | |

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| F000224 SS=D | 483.13(c)<br>PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>Based on record review, observation, and interview the facility failed to ensure a resident remained free from abuse in that one resident had narcotic pain patches removed. This affected 1 of 9 residents who met the criteria for abuse. (Resident #C)<br><br>Findings include:<br><br>1. Resident #C's record was reviewed on 8/8/13 at 3:12 p.m. The record indicated Resident #C was admitted with diagnoses that included, but were not limited to, diabetes, high blood pressure, backache, cerebral vascular disease, cognitive impairment, chronic back pain, insulin dependent diabetes mellitus, Alzheimer's disease, lumbar spinal stenosis, peripheral edema, hearing loss, insomnia, depression, dementia with mood disturbance, and chronic pain syndrome.<br><br>A Quarterly Minimum Data Set Assessment (MDS), dated 6/1/13, | F000224 | F 224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility repectfully requests paper review IDR for tag F 224. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Resident #C was not harmed by alleged deficient practice. * All staff inserviced on misappropriation of resident property and abuse directly after incident occurred on July 19, 2013. *Resident #C Fentanyl patches are checked for placement every shift How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged | 09/06/2013 |

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| | indicated Resident #C had severe impairment in cognitive skills for daily decision making and was on a scheduled pain medication regimen.<br><br>Physician's recapitulation orders dated 7/01/13 through 7/31/13 indicated an order for Fentanyl 75 micrograms (mcg) per hour, apply 1 patch topically every 72 hours for pain, with a start date of 4/17/13.<br><br>A Physician's telephone order, dated 7/16/13, (no time written on the order) indicated "1X order Fentanyl Patch 75 mcg." This order indicated a care plan update of: "Patch mistakenly removed".<br><br>A Physician's telephone order clarification dated 7/16/13 indicted: "Order clarification. (1) Fentanyl 75 mcg per hour. Apply q (every) 3 days. Apply Oppsite (clear adhesive cover) over Patch. DX (diagnosis): Chronic Back Pain. (2) [change] Seroquel DX: to Dementia [with] Psychosis. (3) [check] placement [of] patch q shift."<br><br>A Physician's telephone order dated 7/18/13 at 8:00 p.m., indicated an order for "1X Fentanyl patch replacement." This order had a notation of "clarification" written below | | deficient practice. * All staff inserviced by the Director of Nursing and/or designee on misappropriation of resident property and abuse directly after incident occurred on July 19, 2013 and again on August 27, 2013 *Director of Nursing and/or designee conducted an audit of all narcotic patches to ensure all were in place per physician's order What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff inserviced by the Director of Nursing and/or designee on misappropriation of resident property and abuse after incident occurred on July 19, 2013 and again on August 27, 2013 * Director of Nursing and/or designee will complete 100% audit on all narcotic patches and initiate checks every shift to ensure placement *Inservicing for all new staff over abuse/misappropriation of resident funds/property was conducted on August 27, 2013 and will be completed upon hire and on annual basis by Director of Nursing and/or designee How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? * An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and | |

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| | the order.<br><br>A Physician's telephone order dated 7/19/13 at 10:30 a.m., indicated "Fentanyl patch 75 mcg, Apply X1 et (and) Keep schedule to every 72 hrs (hours) starting today." This order included a care plan update of: "Pain patch off, Replace patch/Reduce pain."<br><br>A reportable incident of misappropriation of property was provided by the Director of Health Services on 8/9/13 at 12:23 p.m. The incident was dated 7/19/13 and indicated, but was not limited to: "Resident [#C] has order for Fentanyl Patch 75 mcg. Last changed on 7/17/13 at 8am, patch found missing on 7/18/13 at 2:20 p.m. Suspected to have fallen off. Order received to reapply patch x1. Patch was reapplied at 3:30pm with tegaderm (clear adhesive) covering to keep in place on mid back. Checked at 10pm and was reported still in place. Patch found missing on 7/19/13 at 6:20 am during check...." The DHS indicated the daily staffing was reviewed and all staff that were working during the time frame when the Fentanyl patches went missing were tested for drugs. | | quarterly X1 for at least 6 months<br>* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met. | |

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| | Resident #C was observed on 8/7/13 at 2:45 p.m., walking around with her walker. The resident could speak to others, was very confused, and had no indications of being in pain. She was very calm, and had no facial grimaces nor guarding of any parts of her body.<br><br>2. A reportable incident of an allegation of resident to resident abuse was provided by the Director of Health Services on 8/13/13 at 10:46 a.m. The incident, that involved Resident #L and Resident #M, had occurred on 8/10/13 at 3:30 p.m. The residents were separated, the DNS and Executive Director notified, and one on one supervision was initiated with Resident #L. The incident was investigated and the DHS provided a dated e-mail that indicated the incident was reported to the ISDH on 8/11/13 at 12:12 p.m., which was approximately 21 hours after the incident occurred.<br><br>3. An investigation of an allegation of staff to resident abuse was provided by the Director of Health Services on 8/13/13 at 10:46 a.m. The incident involved QMA #24, had occurred on 7/27/13 at 9:00 a.m., and indicated: "Reported that staff #1 (QMA #24) pushed back Resident #K's head and | | | |

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| | stated rudely "It's time to eat" then went to Resident #J and stated, "I don't have time to feed you so you need to feed yourself. Type of Injury/Injuries: Residents were assessed and no injuries noted...." An investigation was begun and this incident was reported to the ISDH on 7/27/13 at 2:55 p.m., which was almost 6 hours later.<br><br>During an interview on 8/14/13 at 10:36 a.m., the DHS indicated she takes every allegation of abuse very seriously. The employee, QMA #24 had worked here and did not have any allegations against her. The DHS indicated she investigates by getting statements to rule out the allegation, and checks if their tone was rough or was it misconstrued as rough, or were the employees misunderstanding. She also indicated the two CNA's did not report it to the supervisor until 11:00 a.m. and she stressed the importance of reporting immediately when she did the abuse inservices.<br><br>4. An investigation of a reportable allegation of staff to resident abuse was provided by the DHS on 8/8/13 at 3:20 p.m. The investigation indicated that a family member of a discharged resident (Resident #A) had reported two CNA's to the facility on 11/29/12 | | | |

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| | that were "rushing with care", and also were rough and rude. Resident #A had been discharged in 9/2013.<br><br>During an interview on 8/8/13 at 3:20 p.m., the DHS indicated the facility got a letter from a resident's family member on 11/29/12, that contained a list of formal concerns. She indicated she went through the entire letter and investigated all the allegations, gave each allegation a number and put in what they did to correct it if it was substantiated. The DHS indicated she was a consultant at that time and assisted the Executive Director, (ED) who is no longer at the facility, along with the Director of Health Services at that time. She indicated she didn't know if the ED got back with the mother, but they let the other agency involved know about the results, because the other agency had sent a letter to find out what they were going to do about it. They handled it like a legal matter. One CNA is no longer employed, and the other is still here. The ED provided a copy of a letter, that had been sent by the former ED to the other agency, with an attachment with the information gathered from the investigation.<br><br>During an interview on 8/14/13 at | | | |

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| | 5:14 p.m., the DHS indicated they could not find confirmation the allegations had been reported to the ISDH and other agencies, so they went ahead and reported this on 8/14/13 at 5:01 p.m.<br><br>A policy, titled "Abuse Prohibition, Reporting, and Investigation" policy and procedure, was provided by the Executive Director on 8/12/13 at 11:04 a.m. The policy indicated, but was not limited to, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...Misappropriation of Resident Funds or Property - the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents...."<br><br>3.1-27(a)(3)<br>3.1-28(a) | | | |

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| F000225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | F000225 | F 225 INVESTIGATE/REPORT | 09/06/2013 |

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| | Based on record review and interview, the facility failed to immediately report allegations of abuse to the State Agency. This affected 6 of 9 residents reviewed who met the criteria for abuse. (Residents #C, L, M, J, K, and A)<br><br>Findings include:<br><br>1. A reportable incident of misappropriation of property was provided by the Director of Health Services on 8/9/13 at 12:23 p.m. The incident was dated 7/19/13 and indicated, but was not limited to: "Resident [#C] has order for Fentanyl Patch 75 mcg. Last changed on 7/17/13 at 8am, patch found missing on 7/18/13 at 2:20 p.m. Suspected to have fallen off. Order received to reapply patch x1. Patch was reapplied at 3:30pm with tegaderm (clear adhesive) covering to keep in place on mid back. Checked at 10pm and was reported still in place. Patch found missing on 7/19/13 at 6:20 am during check...." The DHS indicated the daily staffing was reviewed and all staff that were working during the time frame when the Fentanyl patches went missing were tested for drugs.<br><br>On 8/13/13 at 10:46 a.m., the Director | | ALLEGATIONS/INDIVIDUALS<br>The facility repectfully requests paper review IDR for tag F 225. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>* Resident #C, L, M, J, K, and A were not harmed by alleged deficient practice. * All staff inserviced on abuse policy and procedure abuse on August 27, 2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 What measures will be put into place or what systemic changes you will make to ensure | |

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| | of Health Services (DHS) provided an e-mail confirmation that indicated the incident of the misappropriation of Resident #C's Fentanyl patches were reported to the ISDH on 7/19/13 at 2:33 p.m. which was over 24 hours from when the patch was found missing on 7/18/13.<br><br>2. A reportable incident of an allegation of resident to resident abuse was provided by the Director of Health Services on 8/13/13 at 10:46 a.m. The incident, that involved Resident #L and Resident #M, had occurred on 8/10/13 at 3:30 p.m. The residents were separated, the DNS and Executive Director notified, and one on one supervision was initiated with Resident #L. The incident was investigated and the DHS provided a dated e-mail that indicated the incident was reported to the ISDH on 8/11/13 at 12:12 p.m., which was approximately 21 hours after the incident occurred.<br><br>3. An investigation of an allegation of staff to resident abuse was provided by the Director of Health Services on 8/13/13 at 10:46 a.m. The incident involved QMA #24, had occurred on 7/27/13 at 9:00 a.m., and indicated: "Reported that staff #1 (QMA #24) pushed back Resident #K's head and | | that the deficient practice does not recur? * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 * Executive Director and/or designee will place guide at each nurses' station regarding abuse/neglect/misappropriation of resident property or funds/injuries of unknown origin with instructions to complete the guide. Information from the guide will then be relayed to Executive Director and/or designee which will allow Executive Director and/or designee to report immediately to ISDH *Inservicing for all new staff over abuse/misappropriation of resident funds/property was conducted on August 27, 2013 and will be completed upon hire and on annual basis by Director of Nursing and/or designee How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? * An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met. | |

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| SEYMOUR CROSSING | 707 S JACKSON PARK DR<br>SEYMOUR, IN 47274 |

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| | stated rudely "It's time to eat" then went to Resident #J and stated, "I don't have time to feed you so you need to feed yourself. Type of Injury/Injuries: Residents were assessed and no injuries noted...." An investigation was begun and this incident was reported to the ISDH on 7/27/13 at 2:55 p.m., which was almost 6 hours later.<br><br>During an interview on 8/14/13 at 10:36 a.m., the DHS indicated she takes every allegation of abuse very seriously. The employee, QMA #24 had worked here and did not have any allegations against her. The DHS indicated she investigates by getting statements to rule out the allegation, and checks if their tone was rough or was it misconstrued as rough, or were the employees misunderstanding. She also indicated the two CNA's did not report it to the supervisor until 11:00 a.m. and she stressed the importance of reporting immediately when she did the abuse inservices.<br><br>4. An investigation of a reportable allegation of staff to resident abuse was provided by the DHS on 8/8/13 at 3:20 p.m. The investigation indicated that a family member of a discharged resident (Resident #A) had reported two CNA's to the facility on 11/29/12 | | | |

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| | that were "rushing with care", and also were rough and rude. Resident #A had been discharged in 9/2013.<br><br>During an interview on 8/8/13 at 3:20 p.m., the DHS indicated the facility got a letter from a resident's family member on 11/29/12, that contained a list of formal concerns. She indicated she went through the entire letter and investigated all the allegations, gave each allegation a number and put in what they did to correct it if it was substantiated. The DHS indicated she was a consultant at that time and assisted the Executive Director, (ED) who is no longer at the facility, along with the Director of Health Services at that time. She indicated she didn't know if the ED got back with the mother, but they let the other agency involved know about the results, because the other agency had sent a letter to find out what they were going to do about it. They handled it like a legal matter. One CNA is no longer employed, and the other is still here. The ED provided a copy of a letter, that had been sent by the former ED to the other agency, with an attachment with the information gathered from the investigation.<br><br>During an interview on 8/14/13 at | | | |

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| | 5:14 p.m., the DHS indicated they could not find confirmation the allegations had been reported to the ISDH and other agencies, so they went ahead and reported this on 8/14/13 at 5:01 p.m.<br><br>A policy, titled "Abuse Prohibition, Reporting, and Investigation" policy and procedure, was provided by the Executive Director on 8/12/13 at 11:04 a.m. The policy indicated, but was not limited to, "It is the policy of American Senior Communities to protect residents form abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents...5. All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24 hours of the report...7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health...Copies of the completed | | | |

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| | investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations...."<br><br>This Federal tag relates to Complaint IN00128887.<br><br>3.1-28(c) | | | |

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| F000226 SS=E | 483.13(c)<br>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to implement their policies and procedures regarding reporting, in that allegations of abuse were not reported immediately to the ISDH and other agencies. This affected 6 of 9 residents reviewed for abuse reporting. (Residents #C, L, M, J, K, and A)<br><br>Findings include:<br><br>1. A reportable incident of misappropriation of property was provided by the Director of Health Services on 8/9/13 at 12:23 p.m. The incident was dated 7/19/13 and indicated, but was not limited to: "Resident [#C] has order for Fentanyl Patch 75 mcg. Last changed on 7/17/13 at 8am, patch found missing on 7/18/13 at 2:20 p.m. Suspected to have fallen off. Order received to reapply patch x1. Patch was reapplied at 3:30pm with tegaderm (clear adhesive) covering to keep in place on mid back. Checked at 10pm | F000226 | F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT,ETC POLICIES The facility repectfully requests paper review IDR for tag F 226. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? * Resident #C, L, M, J, K, and A were not harmed by alleged deficient practice. * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff inserviced by the Director of | 09/06/2013 |

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| | and was reported still in place. Patch found missing on 7/19/13 at 6:20 am during check...."<br><br>On 8/13/13 at 10:46 a.m., the Director of Health Services (DHS) provided an e-mail confirmation that indicated the incident of the misappropriation of Resident #C's Fentanyl patches was reported to the ISDH on 7/19/13 at 2:33 p.m. which was over 24 hours from when the patch was found missing on 7/18/13.<br><br>2. A reportable incident of an allegation of resident to resident abuse was provided by the Director of Health Services on 8/13/13 at 10:46 a.m. The incident involved Resident #L and Resident #M and had occurred on 8/10/13 at 3:30 p.m. The incident was investigated and the DHS provided a dated e-mail that indicated the incident was reported to the ISDH on 8/11/13 at 12:12 p.m. which was approximately 21 hours after the incident occurred.<br><br>3. An allegation of staff to resident abuse, that involved QMA #24, had occurred on 7/27/13 at 9:00 a.m. The incident indicated an investigation was begun and reported to the ISDH on 7/27/13 at 2:55 p.m., which was almost 6 hours later. | | Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff inserviced by the Director of Nursing and/or designee on abuse policy and procedure and reporting immediately on August 27, 2013 * Executive Director and/or designee will place guide at each nurses' station regarding abuse/neglect/misappropriation of resident property or funds/injuries of unknown origin with instructions to complete the guide. Information from the guide will then be relayed to Executive Director and/or designee which will allow Executive Director and/or designee to report immediately to ISDH *Inservicing for all new staff over abuse/misappropriation of resident funds/property was conducted on August 27, 2013 and will be completed upon hire and on annual basis by Director of Nursing and/or designee How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? * An Abuse Prohibition and Investigation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months | |

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| | During an interview on 8/14/13 at 10:36 a.m., the DHS indicated the two CNA's did not report it to the supervisor until 11:00 a.m.<br><br>4. An investigation of a reportable allegation of staff to resident abuse was provided by the DHS on 8/8/13 at 3:20 p.m. The investigation indicated that a family member of a discharged resident (Resident #A) had reported two CNA's to the facility that were "rushing with care" and also were rough and rude to the resident to the facility on 11/29/12. Resident #A had been discharged in 9/2012.<br><br>During an interview on 8/14/13 at 5:14 p.m., the DHS indicated they could not find confirmation the allegations had been reported to the ISDH and other agencies, so they went ahead and reported this on 8/14/13 at 5:01 p.m.<br><br>A policy, titled "Abuse Prohibition, Reporting, and Investigation" policy and procedure, was provided by the Executive Director on 8/12/13 at 11:04 a.m. The policy indicated, but was not limited to, "It is the policy of American Senior Communities to protect residents form abuse including physical abuse, sexual | | * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 100% is not met. | |

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| | abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds...1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents...5. All abuse allegations/abuse must be reported to the Executive Director immediately...7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health...Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations...."<br><br>This Federal tag relates to Complaint IN00128887.<br><br>3.1-28(a) | | | |

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| F000246 SS=D | 483.15(e)(1)<br>REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. | F000246 | F 246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to resident and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #H was not harmed by alleged deficient practice *Resident #H still currently on thickened liquids *Thickened liquids will be provided at bedside in insulated container *All staff inserviced on hydrational needs on September 6, 2013 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. * Residents who reside in this facility have the potential to be affected by the alleged deficient practice * Director of Nursing and/or designee completed hydration assessments on all residents who | 09/06/2013 |

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| | | | receive thickened liquids *Thickened liquids will be provided at bedside in insulated container * All staff inserviced by the Director of Nursing and/or designee on hydrational needs on September 6, 2013 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? * All staff inserviced by the Director of Nursing and/or designee on hydrational needs on September 6, 2013 *Thickened liquids will be provided at bedside in insulated container *Activity assistants will offer hydration to all residents when passing hydration cart at designated times each day * Director of Nursing and/or designee will be responsible to ensure hydration cart is being utilized at each designated time * Director of Nursing and/or designee will complete hydration assessments on all residents who receive thickened liquids quarterly, annually and with any significant change *Licensed nurses will ensure insulated containers will be provided at bedside for residents receiving thickened liquids on all shifts *Director of Nursing and/or designee will ensure all residents are assessed for hydrational needs between each meal How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will | |

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| | | | be put into place? * An Altered Fluid Consistency CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 95% is not met. | |
| | Based on observation, interview and record review the facility failed to provide fluids to one resident as preferred for 1 of 2 residents reviewed for adequate fluid intake of 2 residents who met the criteria for hydration (Resident #H).<br><br>Finding include:<br><br>Interview with Resident #H, on 8-6-13 at 9:48 a.m., indicated the she did not receive the fluids she wanted between meals. The resident indicated she was on thickened fluids and the facility did not give her anything to drink in her bedroom. The resident indicated if she was sitting in the hallway the staff would give her something to drink. The resident indicated she got thirsty when she was in her bedroom.<br><br>During observation, on 8-6-13 at 10:10 a.m., Resident #H did not have any fluids in her bedroom. | | | |

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Interview with Resident #H, on 8-7-13 at 2:50 p.m., indicated the staff had not given her anything to drink in her bedroom. Resident #H indicated the staff gave her something to drink when she sat in the hallway and with her medication. The resident indicated she got thirsty when she was in her bedroom and there was no set time she received fluids. The resident stated "well it is the way it is I guess".

Interview with CNA #2, on 8-7-13 at 2:53 p.m., indicated fluids were passed on second shift at 2:00 p.m. and at 8:00 p.m. CNA #2 indicated there was a list of residents on the hydration cart of the type of fluids each resident received. CNA #2 indicated activity staff passed the fluids at 2:00 p.m.

Interview with Activity staff #5, on 8-7-13 at 3:01 p.m., indicated she had passed fluids on two hallways and was now passing it on the third hallway. Activity staff #5 indicated she had a list of all the residents on the hydration cart with the type of fluid they received. Activity staff #5 indicated the residents who received thickened liquids a CNA stayed with the resident while they drank their

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| | fluids. Activity staff #5 provided the list of residents on the hydration cart, Resident #H was listed as nectar thick liquids (liquid that is a thick consistency to help prevent choking).<br><br>Interview with Resident #H family member, on 8-7-13 at 3:05 p.m., indicated the resident was thirsty a lot. The family member indicated the facility used to keep fluids available in her room, but did not anymore. The family member indicated he did not know if the resident's medication was making her thirsty, but when he came to visit she seemed thirsty a lot. Resident #H indicated at this time she was thirsty. Observation at this time Activity staff #5 walked past Resident #H's bedroom and did not offer the resident any fluids.<br><br>Interview with Activity staff #5, on 8-7-13 at 3:11 p.m., indicated yes she was done passing the hydration cart to the residents. When queried why Resident #H was not offered any fluids, Activity staff #5 indicated she must have missed giving fluids to Resident #H and would get the resident something to drink at this time.<br><br>Interview with Activity staff #5, on 8-7-13 at 3:20 p.m., indicated she told | | | |

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| | Resident #H's assigned CNA the resident wanted a nectar thick coke.<br><br>Interview with CNA #2, on 8-7-13 at 4:00 p.m., indicated the Activity staff did not inform her that Resident #H wanted something to drink. CNA #2 indicated Activity staff #5 asked her if a coke could be made nectar thick and she told her the dietary staff could make a nectar thick coke. CNA #2 indicated she would go get Resident #H a nectar thick coke now.<br><br>Interview with CNA #2, on 8-7-13 at 4:30 p.m., indicated she gave Resident #H a nectar thick coke and the resident liked it.<br><br>Review of the record of Resident #H, on 8-8-13 at 11:34 a.m., indicated the resident's diagnoses included, but were not limited to, major depressive disorder, anxiety, chronic urinary tract infections, Parkinson's disease, constipation and hypertension.<br><br>The physician's recapitulation orders for Resident #H, dated August 2013, indicated the resident's diet order was mechanical soft with puree soups and fruit and nectar thick liquids.<br><br>The Minimum Data Set (MDS) assessment, dated 6-17-13, for | | | |

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| | Resident #H indicated the resident required extensive assistance of person to eat and drink.<br><br>The nutrition risk assessment, dated 6-27-13, for Resident #H indicated the resident was not on a fluid restriction.<br><br>The hydration management policy provided by Medical records, on 8-7-13 at 6:40 p.m., indicated fresh water will be passed to all residents, unless medically contraindicated, on each shift.<br><br>This federal tag relates to complaint number IN00128887.<br><br>3.1-3(v)(1) | | | |

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| F000279 SS=D | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | F000279 | F 279 DEVELOP COMPREHENSIVE CAREPLANS The facility repectfully requests paper review IDR for tag F 279. The facility has evidence for the following tags to support the deficiencies should not have been sited. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required and any services that would otherwise be required but not provided due to the residents exercise of rights including the right to refuse treatment. What | 09/06/2013 |

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| | | | corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #58 was not harmed during alleged deficiency practice *Resident #58 careplan has been updated to reflect any positioning/comfort concerns with current gerichair *Resident #58 is currently in occupational therapy to address any comfort concerns How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected by the alleged deficient practice *Licensed Nurses and IDT have been re-educated on updating careplans to reflect the current status of each resident by SDC/designee on September 6, 2013 *All residents with positioning concerns were evaluated by PT/OT to ensure appropriate positioning devices were in place and care plans were updated accordingly What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur *Careplans are reviewed and updated by IDT at least on admission, quarterly, and with any significant change to ensure all residents with positioning devices have appropriate careplan in place *Licensed Nurses and IDT have been re-educated on | |

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| | Based on observation, record review, and interview, the facility failed to ensure care plans were developed to address the need for positioning while in a geri chair for 1 of 34 residents whose care plans were reviewed. (Resident #58) | | updating careplans to reflect the current status of each resident by SDC/designee on September 6, 2013 *All residents with positioning concerns were evaluated by PT/OT to ensure appropriate positioning devices were in place and care plans were updated accordingly *Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action. *DNS/designee will monitor for compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *A Careplan updating CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 95% is not met. | |

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| | Findings include:<br><br>During observation and interview with Resident #58 on 08/06/13 at 9:18 a.m., Resident #58 was observed to be leaning to his right side when up in geri chair. Resident #58 reports that he always leans that way and is not uncomfortable. When asked about using a pillow on his right side to help him sit more upright, Resident #58 indicated that he thought that might work. Resident #58 also indicated that staff has not offered to try a pillow for this for him.<br>During observation and interview with Resident #58 on 08/07/13 at 9:12 a.m., Resident #58 was observed up in geri chair with blue foam bracing to his right side and some pillows under his legs. Resident # 58 indicated that he is more comfortable.<br>The clinical record for Resident # 58 was reviewed on 08/07/13 at 3:33 p.m. The record indicated a plan of care for activities of daily living dated 05/19/11 with approach noted that resident sits up in geri chair for positioning at this time. | | | |

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| | During observation of Resident #58 on 08/07/13 at 4:13 p.m., Resident #58 was observed enjoying the Elvis Impersonator show while sitting straighter in the geri chair with blue foam pillow to right side.<br>During interview with PT (Physical Therapist) #6, on 8/12/2013 at 2:01 p.m., for current therapy documentation and history, PT #6 indicated that he only had access to current PT documentation. PT #6 printed most current Physical Therapy Plan of Care notes dated 07/16/13 for Lower Extremity edema control/strengthening. Functional deficit - balance/static - unable to maintain balance without mod/max support BLE (bilateral lower extremity) hip IR limited impairing positioning in chair: 0-5 degrees - Patient demonstrates AAROM (Active assisted range of motion) to BLE hip internal rotation from 0 to 5 degrees - with facial grimacing. The pt will increase BLE internal hip rotation to 25 degrees to avoid skin breakdown and to decrease burden of care and improve sitting posture/muscular.<br><br>During an interview on 08/13/13 at 10:14 a.m., CNA's #9 and #10 indicated that the blue foam wedge and rectangle blue wedge in the geri | | | |

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| | chair of Resident #58 had been used with him for a long time for positioning in bed. They indicated that they started to use them for him after we (surveyors) interviewed Resident #58 about his chair positioning the other day. They also indicated that Resident's wheelchair broke a few weeks ago and Resident #58 chose to use the geri chair instead of the wheelchair.<br><br>The current clinical plans of care were reviewed, on 08/14/13 at 11:00 a.m., for Resident #58, and these records did not include a care plan for positioning.<br><br>3.1-35(a) | | | |

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| F000281 SS=D | 483.20(k)(3)(i)<br>SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>Based on record review and interview, the facility failed to ensure a resident had a physician's order for capillary blood glucose monitoring. This affected 1 of 34 residents reviewed for physician orders in a sample of 34. (Resident #5)<br><br>Findings include:<br><br>A record review was conducted for Resident #5, on 8/14/13 at 9:30 a.m., and indicated Resident #5's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, pancreatitis, chronic alcohol abuse, and hypertension.<br><br>Signed physician orders for 8/1/13 through 8/31/13 included, but were not limited to, the following medications:<br><br>1. "Lantus 100/ml (millimeters) INJ inject 25 units sub-Q daily at 8pm bedtime (7/5/13)"<br>2. "Novolog 100 /ml INJ inject sub-Q per sliding scale: 151-200= 3 units; 201-250=6 units; | F000281 | F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #5 was not harmed during alleged deficiency practice *Resident #5 physician's orders were clarified to include complete accucheck order How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected by the alleged deficient practice *Licensed Nurses and nurse managers were inserviced on ensuring complete accucheck orders are present in the Medication Administration Record *100% audit of all accucheck orders on diabetic residents was completed by September 6, 2013<br>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? *Licensed Nurses and nurse managers were inserviced on ensuring complete accucheck | 09/06/2013 |

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| | 251-300=8 units; 301-350 = 12 units; 351-400 = 14 units; > 400 = 16 units - document flow sheet"<br>3. " Glucagen Hypokit INJ Inject 1ml (1mg) IM as needed if BG <60 and unresponsive to oral glucose for DX: DM"<br><br>No physicians order related to capillary blood glucose monitoring frequency was found on physician orders, medication administration records, or in the resident's medical record. Resident #5's "Capillary Blood Glucose Monitoring Tool" flow sheet was observed to have the resident's blood glucose documented 4 times daily. "QID" (four times per day) was hand-written at the top of the first page of the resident's flow sheet.<br><br>An interview was conducted, on 8/13/13 at 11:50 a.m., with LPN #13, LPN #12, and LPN #14. Each LPN indicated that there should be a physician's order for frequency of blood glucose monitoring for those residents receiving insulin and that it should be located on the physician's orders. Additionally, each LPN indicated that there was no standing order or facility policy regarding frequency of blood glucose | | orders are present in the Medication Administration Record *100% audit of all accucheck orders on diabetic residents was completed by September 6, 2013 *Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action *Medical Records and/or designee will ensure diabetic orders are appropriate and accurate on a monthly basis during end of the month change over *Director of Nursing and/or designee will audit all orders of new admission/readmissions to the facility to ensure accuracy of diabetic orders *DNS/designee will monitor for compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *A Pharmacy Services CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 95% is not met | |

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| | monitoring for residents receiving insulin. Following a thorough review of Resident #5's chart, LPN #13 indicated that she could not locate any physician's order for glucose monitoring anywhere in the resident's chart, including the admission orders. LPN #13 also indicated that there was no order regarding blood glucose testing related to the resident's sliding scale. When asked how frequently she would perform capillary blood glucose monitoring for a resident who received insulin, LPN #13 indicated, "If the sliding scale says AC (before meals) and HS (hour of sleep), I do it four times a day."<br><br>In an interview with the Director of Nursing (DON), on 8/13/13 at 12:05 p.m., she indicated that orders for capillary blood glucose monitoring frequency should be located in physician's orders and that the facility does not have a standing order or facility policy regarding frequency of blood glucose monitoring for residents receiving insulin.<br><br>On 8/13/13, at 1:45 p.m., the DON produced updated physician's orders, with hand-written capillary blood glucose monitoring indicating four times daily. | | | |

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| | In an interview on 8/14/13 at 5:00 p.m., the DON indicated that they did not have a written policy and procedure related to physician order requirements for performing capillary blood glucose monitoring.<br><br>A copy of the facility policy and procedure entitled "Blood Glucose Monitoring" was provided by the DON on 8/13/13 at 2:30 p.m. The policy indicated, but was not limited to, "It is the policy of this facility to administer immediate treatment of hypoglycemia". The procedure indicated, "Residents who have a physician's order to obtain routine capillary blood glucose will have a physician's order specifying the blood glucose parameters requiring physician notification".<br><br>"Fundamentals of Nursing Concepts, Process, and Practice", Third Edition, indicated: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would be detrimental to clients...The physician should write all orders, and the nurse must make sure that they are transcribed correctly...." | | | |

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| F000309 SS=D | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F000309 | F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #96 or #58 was not harmed during alleged deficiency practice *Resident #58 is currently in occupational therapy to address any comfort concerns with care plan to reflect any changes for positioning *Resident #96 is currently free of infection in wound How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected by the alleged deficient practice *All staff will be inserviced on infection control by | 09/06/2013 |

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| | | | September 6, 2013<br>*Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action *All residents with positioning concerns were evaluated by PT/OT to ensure appropriate positioning devices were in place and care plans were updated accordingly<br>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?<br>*All staff will be inserviced by Director of Nursing Services and/or designee on infection control by September 6, 2013<br>*Staff Development Coordinator and/or designee will perform skills validations on handwashing on all staffed by September 6, 2013<br>*Staff Development Coordinator and/or designee will perform skills validations on wound dressing changes on all licensed nurses by September 6, 2013<br>*Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action *Director of Nursing Services and/or designee will monitor for compliance *All residents with positioning concerns were evaluated by PT/OT to ensure appropriate positioning devices were in place and care plans were updated accordingly How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality | |

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| | | | assurance program will be put into place? *An infection control CQI tool will be utilized by the Director of Nursing and/or designee weekly x4 weeks, monthly x2 months and quarterly x1 for at least 6 months *A Range of Motion CQI tool will be utilized by the Director of Nursing and/or designee weekly x4 weeks, monthly x2 months and quarterly x1 for at least 6 months *Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 95% is not met | |
| | Based on observation, record review, and interview, the facility failed to address one resident's need for positioning while in a geri chair (Resident #58) and failed to promote healing and prevent infection for a resident with wounds (Resident #96). This affected 1 of 3 residents who met the criteria for positioning and 1 of 3 residents who met the criteria for wound care.<br><br>Findings include:<br>1. During observation and interview with Resident #58 on 08/06/13 at 9:18 a.m., Resident #58 was observed to be leaning to his right side when up in geri chair. Resident #58 reports that he always leans that way and is not | | | |

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| | uncomfortable. When asked about using a pillow on his right side to help him sit more upright, Resident #58 indicated that he thought that might work. Resident #58 also indicated that staff has not offered to try a pillow for this for him.<br>During observation and interview with Resident #58 on 08/07/13 at 9:12 a.m., Resident #58 was observed up in geri chair with blue foam bracing to his right side and some pillows under his legs. Resident # 58 indicated that he is more comfortable.<br>The clinical record for Resident # 58 was reviewed on 08/07/13 at 3:33 p.m. The record indicated a plan of care for activities of daily living dated 05/19/11 with approach noted that resident sits up in geri chair for positioning at this time.<br>During observation of Resident #58 on 08/07/13 at 4:13 p.m., Resident #58 was observed sitting straighter in geri chair with blue foam pillow to right side.<br>During interview, on 08/13/13 at 10:14 a.m., CNA's #9 and #10, indicated that the blue foam wedge and rectangle blue wedge in geri chair of Resident #58 had been used with | | | |

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| | him for a long time for positioning in bed but that they started to use them for him after we (surveyors) interviewed Resident #58 about his chair positioning the other day. They also indicated that Resident's wheelchair broke a few weeks ago and Resident # 58 chose to use the geri chair instead of the wheelchair.<br><br>The current clinical plans of care were reviewed, on 08/14/13 at 11;00 a.m., for Resident #58 and these records did not include a care plan for positioning.<br><br>2. Resident #96's record was reviewed on 8/7/13 at 4:10 p.m. The record indicated Resident #96's diagnoses included, but were not limited to: high blood pressure, history of recurrent ulcers on feet, peripheral venous insufficiency, depression, and right stroke with weakness on one side.<br><br>Resident's care plan indicated, "Problem Start Date: 3/11/13: Problem: Skin: Res[ident] has impaired skin integrity: ulcers to R foot - -weeping of lower extremity as well. Refuses to wear protective shoe/sock/boot to right foot. Will refuse for dressings to be changed due to soilage. Educated on risk for | | | |

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| | infection with dressings/drainage. Goal: (target date 10/22/13); Areas will show no signs of infection; Approaches: (most recent update/start date: 8/1/13) "continue to educate when dressings need changed due to drainage or soilage reason for dressing change".<br><br>A review of "Skin Integrity Events - ASC Non-pressure Wound Skin Evaluation Report", dated 3/15/13, and provided by the Director of Nursing (DON) on 8/14/13 at 12:40 p.m., indicated an existing area to the right inner foot originally noted on 2/15/13. The wound measured L 4cm x W 2.4xm X D 0.3cm. The wound was indicated to be "yellow, red" in color and have "moderate purulent drainage."<br><br>Interdisciplinary team (IDT) meeting progress notes, dated 4/3/13 at 3:10 p.m., were provided by the DON on 8/14/13 at 4:10 p.m. The IDT notes indicated: "Resident has wound from lacerations to RT foot that shows minimal improvement."<br><br>IDT meeting progress notes dated 7/6/13 at 10:29 a.m., and provided by the DON on 8/14/13 at 4:10 p.m., indicated Resident #96's diagnosis "...changed from lacerated areas to | | | |

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| | stasis areas on right foot. Mod[erate] amount of yellow drainage noted. No odor noted. Wound bed yellow. Treatment of med honey continues. Res with F/U appt with wound care on 7/15/13. Contributing DX include venous insufficiency, HTN, Hx of stroke, smoker. Currently consumes average of 100% of meals. CNA assignment sheets and CP updated. Will reassess in 1 week. In attendance WN (Wound Nurse), MDS (Minimum Data Set Coordinator), ADNS (Assistant Director of Nursing Services."<br><br>IDT team meeting progress notes dated 8/2/13 at 2:53 p.m., and provided by the DON on 8/14/13 at 4:10 p.m., indicated, "Resident had stasis areas on right foot that has become one wound. Large amount of mucopurulent drainage noted. Foul odor noted. Wound bed lime green with white slough. Area shows no improvement. Treatment of medihoney continues QOD (every other day)".<br><br>Resident #96's care plan was updated on 8/6/13 to discontinue previous treatment to right foot. The care plan indicated, "Apply tender wet active to R foot. Change QD. Secure with kurlex QD". The care | | | |

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| | plan indicated the problem to be that the wound was not improving and had increased drainage. Goals included improvement of the area and decreased drainage. Interventions included the new treatment.<br><br>A review of "Skin Integrity Events - -ASC Non-Pressure Wound Skin Evaluation Report" dated 8/2/13, and provided by the DON 8/14/13 at 4:10 p.m., indicated the right foot wound measurements were: L 8.6cm X W 13.0cm X D 0.2cm. Wound color was indicated to be "lime green with white slough". Wound drainage was indicated to be "large mucopurulent" and odor was "Foul."<br><br>A review of "Skin Integrity Events - -ASC Non-Pressure Wound Skin Evaluation Report", dated 8/9/13 and provided by the DON 8/14/13 at 4:10 p.m., indicated the right foot wound measurements were: L 8.4cm X W 12.8cm X D 0.2cm. Wound color was indicated to be "pink in areas with lime green areas". Wound drainage was indicated to be "light green large amt" and odor was "Moderate".<br><br>IDT meeting progress notes dated 8/9/13 at 4:04 p.m., and provided by the DON on 8/14/13 at 4:10 p.m., indicated; "Resident has stasis areas | | | |

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| | on right foot that has become one wound. Large amount of mucopurulent drainage noted. Foul odor noted. Wound bed lime green with pink areas throughout. Area shows improvement. Will continue current treatment of tender wet."<br><br>An interview and observation of wound care with LPN #13 was conducted on 8/8/13 at 1:21 p.m. LPN #13 indicated she frequently provides wound care and dressing changes for Resident #96 and is familiar with his plan of care. LPN #13 indicated that Resident #96's right foot wound(s) were present on admission and started as "a little cut" as a result of his right foot being run over by a wheelchair. LPN #13 was observed several minutes prior to gathering supplies and entering Resident #96's room. She did not wash her hands or use hand sanitizing gel. LPN #13 was observed placing wound care supplies on Resident #96's bedside table after pushing multiple items, including food and drink, down the length of the table to make room. LPN #13 then placed plastic bags on the floor and a clean cloth pad (chux) on the floor beneath Resident #96's foot as he sat in his wheelchair. LPN #13 then donned gloves and removed | | | |

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| | Resident #96's dressing. LPN #13 removed the gloves and threw them into the plastic bags on the floor. LPN #13 then poured normal saline into a plastic drinking cup and indicated to Resident #96 that she was going to clean his right foot wound as she donned clean gloves. LPN #13 was observed opening packs of 4x4 gauze to clean wound using appropriate technique. Resident #96's right foot wound was observed to cover 75% of the anterior portion of his foot, have a yellow wound bed, a large amount of white slough, and was red and inflamed around the borders. After cleansing the wound, LPN discarded her gloves and donned clean gloves. She was observed to open 2 individually-wrapped dressing packages and place the dressings on the wound. She then wrapped the right foot with gauze kurlex, taped the dressing, and dated and initialed it. LPN #13 then removed her gloves and did not perform any hand hygiene prior to donning new gloves to provide wound care to Resident #96's right lower extremity.<br><br>An interview with the DON on 8/14/13 at 7:30 p.m., the DON indicated her expectations for the staff, regarding hand washing, were: " Before and | | | |

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| | after each resident...anything that is physically soiled or unclean...." When asked specifically about the procedure, she indicated, "Twenty seconds."<br><br>During an observation, on 8/6/13 at 3:30 p.m., Resident #96 was sitting up in a wheelchair watching an activity of an Elvis impersonator in the main dining room. The Kurlex dressing was intact and there was no cover on the dressing on the foot. The foot and bare heel were resting on the floor. The dressing was dirty and slightly frayed around edges.<br><br>During an observation, on 8/8/13 at 12:30 p.m., Resident #96 was eating lunch at the table and seated in his wheelchair. His right foot rested on the floor with the gauze dressing intact and the heel and toes exposed. The dressing was dirty and slightly frayed around edges.<br><br>During an observation, on 8/14/13 at 12:30 p.m., Resident #96 was sitting in the small dining room at a table with dressing intact on his right foot and calf. The foot and heel rested on the floor, the dressing was light yellow-brown around edges, and slightly frayed. | | | |

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| | Review of Hand Hygiene CNA Skills Validation policy/procedure with review date of 03/2012, provided by the DHS, on 08/09/13 at 1:34 p.m., indicated the following was noted under procedure step #6: Use friction for at least 20 seconds.<br><br>A copy of the facility's "Nursing Policy & Procedure for Dressing Change (Incision or Wound) " was provided by the DON on 8/12/13 at 11:00 a.m. The procedure steps indicated the following: "1. Verify resident and physician orders; 2. Provide privacy and explain procedure; 3. Place a trash receptacle next to the bed or a disposable plastic bag at the foot of the bed (or on a chair) to dispose of potentially infectious material during procedure; 4. Wash hands; 5. Set up clean or sterile field to ensure easy access to supplies during procedure; 6. Put on gloves; 7. Remove old dressing from residents and put directly in trash receptacle; 8. Remove gloves and discard; 9. Perform hand hygiene; 10. Put on gloves; 11. Initiate wound care according to physician order; 12. Wound care requirements: a) Cleanse away debris or drainage from the wound; b) Cleanse from the center of wound outward; c) Cleanse in one direction; d) Use a separate | | | |

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| | swab/gauze for each cleansing stroke; e) If drain present...; f) Measure wound as needed; 13. Remove gloves and discard; 14. Perform hand hygiene; 15. Put on gloves; 16. Apply new dressing according to the physician orders...."<br><br>3.1-37(a) | | | |

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| F000371 SS=E | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F000371 | F 371 FOOD PROCEDURE, STORE/PREPARE/SERVE-SANITARY The facility must procure food from sources approved or considered satisfactory by Federal, State or local authorities, and store, prepare, distribute and serve food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? *Resident #87 and #57 were not harmed by the alleged deficiency *Staff Development Coordinator and/or designee will complete handwashing skills validations on all staff by September 6, 2013 *Director of Nursing Services and/or designee will inservice all staff on infection control by September 6, 2013 *Managers will be assigned to dining room area for observation during dining services How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken deficient practice? *Staff Development Coordinator and/or designee will complete | 09/06/2013 |

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| | | | handwashing skills validations on all staff by September 6, 2013 *Director of Nursing Services and/or designee will inservice all staff on infection control by September 6, 2013 *Managers will be assigned to dining room area for observation during dining services to ensure appropriate handwashing and food is handled in a sanitary manner What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? *Staff Development Coordinator and/or designee will complete handwashing skills validations on all staff by September 6, 2013 *Director of Nursing Services and/or designee will inservice all staff on infection control by September 6, 2013 *Managers will be assigned to dining room area for observation during dining services to ensure appropriate handwashing and food is handled in a sanitary manner *Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action *Director of Nursing Services will be responsible for compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *A Meal Observation CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 | |

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| | Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions. This affected 2 of 26 residents observed for serving food under sanitary conditions, during 1 of 2 dining observations in 2 of 2 dining rooms. (Residents #87 and #57)<br><br>Findings include:<br><br>During a dining observation on 8/5/13 at 11:10 a.m., the beverage counter in the main dining room was observed to have 3 partially filled, dirty coffee cups, a pool of spilled brown liquid, an upright disposable coffee lid partially bent and stained with a brown substance, and a torn sugar packet paper.<br><br>During a dining observation on 8/5/13 at 11:20 a.m., the Assistant Director of Nursing Services (ADON) was observed cleaning off trash and used coffee cups from the beverage counter in the main dining room. She was observed to not wash her hands or use hand sanitizer prior to picking | | weeks, monthly x 2 months and quarterly X1 for at least 6 months<br>* Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 95% is not met | |

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| | up a clean coffee cup and a clean lid with the palm of her hand touching the inside of the lid. She was then observed dispensing coffee, placing the lid on the coffee, walking down the hall, and serving to coffee to Resident #87.<br><br>An interview with the Director of Nursing (DON) was conducted, on 8/14/13 at 7:30 p.m. The DON was asked what her expectations for the staff were regarding hand washing. She indicated, "Before and after each resident...anything that is physically soiled or unclean..." When asked specifically about the hand washing procedure, she indicated, "Twenty seconds."<br><br>During the lunch observation, on 08/05/13 at 11:05 a.m., CNA #23 was observed to take covers off drink glasses on a resident's lunch tray in the dining room and then proceeded to pick up the drink glasses to set on table by the top of the drinking glasses. CNA #10 was observed to touch a resident's sandwich bun with her bare hands.<br><br>During the lunch observation on, 08/08/13 at 12:24 p.m., Activity Assistant #4 was observed cutting up a sandwich with her bare hands for | | | |

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| | Resident #57.<br><br>Review of Hand Hygiene CNA Skills Validation policy/procedure with reveiw date of 03/2012, provided by the DHS on 08/09/13 at 1:34 p.m., indicated the following was noted under procedure step #6: Use friction for at least 20 seconds.<br><br>3.1-21(i)(1) | | | |

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| F000441 SS=E | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F000441 | F441 INFECTION CONTROL, PREVENT SPREAD, LINENS | 09/06/2013 |

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| | | | The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Residents #96 and #58 were not harmed by alleged deficient practice and are receiving care following infection control procedures *Director of Nursing Services and/or designee will inservice all staff on infection control, including washing shower chairs and handling dirty lines, by September 6, 2013 *Director of Nursing Services and/or designee will inservice all licensed nurses on wound dressing changes by September 6, 2013 *All Purell hand sanitizer dispenser mounted on walls have been replaced How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *Residents residing in the facility have the potential to be affected by the alleged deficient practice. *Director of Nursing Services and/or designee will inservice all staff on infection control, including washing shower chairs and handling dirty lines, by September 6, 2013 *Director of Nursing Services and/or designee will | |

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| | | | inservice all licensed nurses on wound dressing changes by September 6, 2013 *Staff Development Coordinator and/or designee will complete skills validations on hand washing with all staff by September 6, 2013 *All Purell hand sanitizer dispenser mounted on walls have been replaced What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? *Director of Nursing Services and/or designee will inservice all staff on infection control, including washing shower chairs and handling dirty lines, by September 6, 2013 *Director of Nursing Services and/or designee will inservice all licensed nurses on wound dressing changes by September 6, 2013 *Staff Development Coordinator and/or designee will complete skills validations on hand washing with all staff by September 6, 2013 *All Purell hand sanitizer dispenser mounted on walls have been replaced *Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action *Director of Nursing Services and/or designee will monitor for compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *An infection control CQI tool will be utilized by | |

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| | | | Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 95% is not met. | |

Based on observation, interview, and record review, the facility failed to ensure their infection control policies related to hand hygiene, use of gloves, and wound care were followed for 4 of 15 direct care observations. This affected (Residents #96 and 58)

Findings include:

1. Resident #96's record was reviewed on 8/7/13 at 4:10 p.m. The record indicated Resident #96's diagnoses included, but were not limited to: high blood pressure, history of recurrent ulcers on feet, peripheral venous insufficiency, depression, and right stroke with weakness on one side.

A review of "Skin Integrity Events - ASC Non-pressure Wound Skin Evaluation Report" dated 3/15/13 and provided by the Director of Nursing (DON) on 8/14/13 at 12:40 p.m.,

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| | indicated an existing area to the right inner foot originally noted on 2/15/13. The wound measured L4cm x W2.4xm X D0.3cm. The wound was indicated to be " yellow, red " in color and have "moderate purulent drainage."<br><br>Interdisciplinary team (IDT) meeting progress notes, dated 4/3/13 at 3:10 p.m., and provided by the DON 8/14/13 at 4:10pm indicated, "Resident has wound from lacerations to RT foot that shows minimal improvement."<br><br>IDT meeting progress notes, dated 7/6/13 at 10:29 a.m., and provided by the DON on 8/14/13 at 4:10 p.m., indicated Resident #96's diagnosis " ...changed from lacerated areas to stasis areas on right foot. Mod amount of yellow drainage noted. No odor noted. Wound bed yellow. Treatment of med honey continues. Res with F/U appt with wound care on 7/15/13. Contributing DX include venous insufficiency, HTN, Hex of stroke, smoker. Currently consumes average of 100% of meals. CNA assignment sheets and CP updated. Will reassess in 1 week".<br><br>IDT team meeting progress notes dated 8/2/13 at 2:53 p.m., and | | | |

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| | provided by the DON on 8/14/13 at 4:10 p.m., indicated, " Resident had stasis areas on right foot that has become one wound. Large amount of mucopurulent drainage noted. Foul odor noted. Wound bed lime green with white slough. Area shows no improvement. Treatment of medihoney continues QOD".<br><br>Resident #96's care plan was updated on 8/6/13, to discontinue previous treatment to right foot. Care plan indicated, "Apply tender wet active to R foot. Change QD. Secure with kurlex QD". The care plan indicated the problem to be that the wound was not improving and had increased drainage. Goals included improvement of the area and decreased drainage. Interventions included the new treatment.<br><br>IDT meeting progress notes dated 8/9/13 at 4:04 p.m., and provided by the DON on 8/14/13 at 4:10 p.m., indicated, " Resident has stasis areas on right foot that has become one wound. Large amount of mucopurulent drainage noted. Foul odor noted. Wound bed lime green with pink areas throughout. Area shows improvement. Will continue current treatment of tender wet." | | | |

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| | An interview and observation of wound care with LPN #13 was conducted on 8/8/13 at 1:21 p.m.. LPN #13 indicated she frequently provides wound care and dressing changes for Resident #96 and is familiar with his plan of care. LPN #13 indicated that Resident #96's right foot wound(s) were present on admission and started as "a little cut" as a result of his right foot being run over by a wheelchair. LPN #13 was observed several minutes prior to gathering supplies and entering Resident #96's room. She did not wash her hands or use hand sanitizing gel. LPN #13 was observed placing wound care supplies on Resident #96 ' s bedside table after pushing multiple items, including food and drink, down the length of the table to make room. LPN #13 then placed plastic bags on the floor and a clean cloth pad (chux) on the floor beneath Resident #96's foot as he sat in his wheelchair. LPN #13 then donned gloves and removed Resident #96's dressing. LPN #13 removed the gloves and threw them into the plastic bags on the floor. LPN #13 then poured normal saline into a plastic drinking cup and indicated to Resident #96 that she was going to clean his right foot wound as she donned clean gloves. | | | |

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| | LPN #13 was observed opening packs of 4x4 gauze to clean wound using appropriate technique. Resident #96's right foot wound was observed to cover 75% of the anterior portion of his foot, have a yellow wound bed, a large amount of white slough, and was red and inflamed around the borders. After cleansing the wound, LPN discarded her gloves and donned clean gloves. She was observed to open 2 individually-wrapped dressing packages and place the dressings on the wound. She then wrapped the right foot with gauze kurlex, taped the dressing, and dated and initialed it. LPN #13 then removed her gloves and did not perform any hand hygiene prior to donning new gloves to provide wound care to Resident #96's right lower extremity.<br><br>A copy of the facility's "Nursing Policy & Procedure for Dressing Change (Incision or Wound) " was provided by the DON on 8/12/13 at 11:00 a.m. The procedure steps indicated the following: "1. Verify resident and physician orders; 2. Provide privacy and explain procedure; 3. Place a trash receptacle next to the bed or a disposable plastic bag at the foot of the bed (or on a chair) to dispose of potentially infectious material during | | | |

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| | procedure; 4. Wash hands; 5. Set up clean or sterile field to ensure easy access to supplies during procedure; 6. Put on gloves; 7. Remove old dressing from residents and put directly in trash receptacle; 8. Remove gloves and discard; 9. Perform hand hygiene; 10. Put on gloves; 11. Initiate wound care according to physician order; 12. Wound care requirements: a) Cleanse away debris or drainage from the wound; b) Cleanse from the center of wound outward; c) Cleanse in one direction; d) Use a separate swab/gauze for each cleansing stroke; e) If drain present...f) Measure wound as needed; 13. Remove gloves and discard; 14. Perform hand hygiene; 15. Put on gloves; 16. Apply new dressing according to the physician orders...."<br><br>Review of Hand Hygiene CNA Skills Validation policy/procedure with review date of 03/2012, provided by the DHS on 08/09/13 at 1:34 PM, indicated the following was noted under procedure step #6: Use friction for at least 20 seconds.<br><br>An interview with the DON was conducted on 8/14/13 at 7:30 p.m. The DON was asked what her expectations for the staff are | | | |

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| | regarding hand washing. She indicated, "Before and after each resident....(pause) anything that is physically soiled or unclean... (pause)..."When asked specifically about the procedure, she indicated, "Twenty seconds."<br><br>2. During a random, continuous observation on 8/14/13, between 12:50 p.m. and 12:53 p.m., QMA #23 was observed walking down the main hallway blowing and wiping her nose with a tissue. She then walked into the main dining room and was observed removing a dirty coffee cup from a dining table and placing it on a counter. QMA #23 was then observed to walk across the dining room to Resident #58, who was being assisted by Activities Assistant #19. QMA #23 picked up a paper towel from Resident #58's table with her bare hands and wiped his mouth and chin; which was observed to be covered in layer of clear-cream colored substance.<br><br>3. During the following random observations, the "Purell" hand sanitizer dispensers were observed to be empty on A-hall of the facility:<br><br>On 8/5/13 at 3:31 p.m., the wall-mounted dispenser between | | | |

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| | rooms 920 and 921 was empty.<br>On 8/8/13 at 9:30 a.m., the wall-mounted dispenser between rooms 921 and 919 was empty.<br>On 8/8/13 at 12:25 p.m., the wall-mounted dispenser between the " Spa " room and room 329 was empty.<br><br>During observation in dining room on 08/08/13 at 12:44 p.m., an unidentified aide was observed to carry uncovered dining room linens clutched to her uniform with her bare arms.<br><br>3.1-18(j)<br>3.1-18(l)<br>3.1-19(g)(1)(2)(3) | | | |

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| F000465 SS=D | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>Based on observation, interview, the facility failed to ensure the environment was sanitary in that soiled linen was left in a resident's room, handwashing sinks were not accessible, and shower chairs were not sanitized according to directions. This affected 1 of 1 resident (Resident #3) and 1 of 3 shower rooms.<br><br>Findings included:<br><br>1. On 8/7/13 at 9:10 a.m., room #913-A was observed to have balled up, visibly moist linens on the floor under a sliding bedside table. A faint odor of urine was observed. Resident #3 was not present in her room.<br><br>On 8/7/13 at 9:20 a.m., Resident #3 was observed sitting in her wheelchair in room #913 - A. The same balled up, visibly moist linens remained on the floor in the same location.<br><br>On 8/7/13 at 9:30 a.m., following constant observation of A-hall, the same linens were observed balled up | F000465 | F465 SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Resident #3 was not harmed by alleged deficient practice *Dirty laundry was removed from room of resident #3 *Soiled utility rooms were rearranged to ensure the sink was free of objects in path *Director of Nursing Services and/or designee will inservice all staff on infection control, including washing shower chairs and handling dirty lines, by September 6, 2013 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *Residents residing in the facility have the potential to be affected by the alleged deficient practice *Soiled utility rooms were rearranged to ensure the sink was free of objects in path *Director of Nursing Services and/or designee will inservice all | 09/06/2013 |

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| | on top of Resident #3's sliding bedside table.<br><br>On 8/7/13 at 9:35 a.m., the same linens were observed to be in an open plastic bag on the floor under Resident #3's sliding bedside table.<br><br>2. During the environmental tour on 08/09/13 at 9:05 a.m. with Maintenance #7 and Administrator, the hand wash sinks located in the 700 hall laundry services room and 900 short hall laundry services room were blocked by large trash cans.<br><br>3. During an interview with CNA #8 on 08/09/13 at 9:05 a.m., when asked about facility procedure for cleaning shower chairs between resident use, CNA #8 indicated that they clean with the sanitizer then wipe dry and then proceed to use for next resident. She also indicated that she was unaware about any time requirements with sanitizer before next use.<br><br>During an interview with the DHS on 08/09/13 at 11:40 a.m., she indicated the procedure for wiping down shower chair equipment is to spray the shower chair, wait 3 minutes, then dry off. DHS also indicated that CNA #8 is being inserviced at this time. | | staff on infection control, including washing shower chairs and handling dirty lines, by September 6, 2013 *Resident #3 encouraged to call for assistance when changing clothes to ensure they are not left in room What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? *Director of Nursing Services and/or designee will inservice all staff on infection control, including washing shower chairs and handling dirty lines, by September 6, 2013 *Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action *Director of Nursing Services and/or designee will monitor for compliance *Director of Nursing Services and/or designee will do rounds each shift to ensure laundry is picked up and shower chairs are cleaned according to manufacturer instructions How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *An infection control CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 95% is not met | |

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| | Review of Material Safety data Sheet and Reference Sheet for TB Quat sanitizer on 08/09/13 at 2:00 PM indicates, under directions for use: It is a violation of Federal Law to use this product in a manner inconsistent with its labeling. Using approved AOAC test methods, in the presence of 5% blood serum and a 3 minute contact time, unless otherwise noted, this product kills the following organisms on hard non-porous inanimate surfaces.<br><br>3.1-19(f) | | | |

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| F000514 SS=D | 483.75(l)(1)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. | F000514 | F514<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility repectfully requests paper review IDR for tag F 514. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. What corrective action(s) will be accomplished for those residents | 09/06/2013 |

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| | 155377 | A. BUILDING 00<br>B. WING | 08/14/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SEYMOUR CROSSING | 707 S JACKSON PARK DR<br>SEYMOUR, IN 47274 |

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| | | | found to have been affected by the deficient practice? *Resident #96 was not harmed by the alleged deficiency practice *Resident #96 event descriptions now match appropriate area of body How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *Residents residing in the facility have the potential to be affected by the alleged deficient practice * Director of Nursing Services and/or designee will inservice all nursing staff on complete and accurate documentation by September 6, 2013 *Director of Nursing Services and/or designee will audit all current open events to ensure accuracy of short description What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? *Staff will be re-educated on complete and accurate documentation upon hire and ongoing thereafter *Non-compliance with facility policy and procedure may result in employee education and/or disciplinary action *Director of Nursing Services and/or designee will monitor for compliance *Director of Nursing Services and/or designee will pull the facility activity report and progress notes every morning to review and ensure accuracy in documentation How the | |

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| | Based on interview and record review, the facility failed to maintain accurately documented clinical records in accordance with accepted professional standards and practices for 1 resident observed for pressure ulcers. (Resident #96)<br><br>Findings included:<br><br>Resident #96's record was reviewed on 8/7/13 at 4:10 p.m. The record indicated Resident #96's diagnoses included, but were not limited to, hypertension, history of recurrent ulcers on feet, peripheral venous insufficiency, depression, and right stroke with hemiparesis.<br><br>Event report entitled "Skin Integrity Events --ASC Pressure Wound Skin Evaluation Report", dated 3/15/13 at 5:40 a.m. and provided by the DON 8/13/13 at 11:30 a.m., indicated, | | corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *A Medical Records-Matrix Maintenance CQI tool will be utilized weekly times four, monthly times two, and quarterly thereafter. *Data will be submitted to the CQI committee for review. If threshold is not achieved, an action plan may be developed to ensure compliance. | |

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| | "Location: posterior scrotum". The report indicated the wound to be stage ll (2) and originally noted on 3/15/13.<br><br>Additional event reports entitled "Skin Integrity Events --ASC Pressure Wound Skin Evaluation Report", dated 3/18/13 at 9:38 a.m. and 3/25/13 at 11:24 a.m., indicated the wound location to be "posterior sacrum." The "date area originally noted", wound characteristics and treatment plans were consistent with the pressure ulcer located on the posterior scrotum originally identified on 3/15/13.<br><br>"Wound Team Review" dated 3/22/13 at 11:22 a.m. indicated, "Area to scrotum improving with current treatment...Will continue current treatments and monitor."<br><br>Event report entitled "Skin Integrity Events --ASC Pressure Wound Skin Evaluation Report", dated 4/1/13 at 7:24 a.m. and provided by the DON 8/13/13 at 11:30 a.m. indicated the location of the wound to be "posterior scrotum", with evaluation notes indicating, "area resolved."<br><br>Progress notes dated 4/16/13 at 10:01 a.m. indicated, "IDT | | | |

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| | (interdisciplinary team) met for wound review. Area to posterior scrotum healed at this time. Current tx of calazinc oint Q shift will be cont until 4/30/13 for prev meas".<br><br>An interview with LPN #13 was conducted on 8/8/13 at 1:21 p.m. She indicated Resident #96 developed a pressure ulcer on his scrotum after admission to the facility and that it was resolved.<br><br>In an interview with the DON on 8/13/13 at 2:39 p.m., she indicated Resident #96 did previously have a pressure ulcer located on his scrotum and did not have a pressure ulcer on his sacrum. She indicated that any documentation citing "sacrum" as the location on any "Skin Integrity Events --ASC Pressure Wound Skin Evaluation Reports" was incorrect and that any report documentation was actually related to the pressure ulcer on Resident #96's scrotum. The DON indicated, "My wound nurse does the chart audits" and that she could provide "no good reason" for the discrepancy in charting.<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | | |

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